Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHRISTUS ST JOHN HOSPITAL
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098-3926

Respondent Name

SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box
Box Number 42

MFDR Tracking Number
M4-05-3155-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based upon review by the insurance carrier, Service Lloyds Insurance Company…and its audit department, alleges the aforementioned claim has been properly paid. On the contrary, specifically, pursuant to Rules 134.401(a)(4) and 134.600 of the TWCC fee guidelines, the claim pertaining to dates of service : 01/05/2004 – 01/06/2004 is to be paid as follows:

Surgical per diem rate $1,118 x one (1) day = $1,118.00

Implants reimbursed @ cost ($5,790) + 10% ($579) = $6,369.00

Total allowable: $7,487.00

Amount paid: $2,466.10

Balance Due: $5,020.90."

Amount in Dispute: $5,020.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary in the response package.

Response Submitted by: Service Lloyds Insurance Co., Harris & Harris, P.O. Box 162443, Austin, TX 78716

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 5, 2004 through January 6, 2004	Inpatient Services	$5,020.90	$5,020.90

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. This request for medical fee dispute resolution was received by the Division on January 4, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on January 11, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 304-Submit Supply House Invoice for additional payment.
   - 520-Inpatient Surgical Per Diem Allowance.
   - M-No MAR.
   - 510-Payment Determined.
   - F-Fee Guideline MAR Reduction.

Findings

1. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.

   28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118."

   A review of the submitted medical bill indicates that the requestor billed for one surgical date.
2. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore 1 multiplied by $1,118.00 = $1,118.00.

   A review of the submitted EOBs supports reimbursement of $1,118.00 for inpatient surgical services; therefore, the requestor was paid in accordance with 28 Texas Administrative Code §134.401(c)(1) and (c)(3)(B).
3. 28 Texas Administrative Code §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in additional to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."
4. 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."

   The requestor states in the position summary that "Implants reimbursed @ cost ($5,790) + 10% ($579) = $6,369.00." A review of the submitted EOB indicates that the respondent paid $1,348.10 based upon "304," "510" and "M." The requestor submitted documentation that supports the cost of $5,790.00 for the implantables; therefore, reimbursement of $5,020.90 ($6,369.00 minus $1,348.10) is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. As a result, the amount ordered is $5,020.90.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $5,020.90 reimbursement for the services in dispute.

Authorized Signature

		10/20/2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.